STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING _____ B. WING _____	03/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN ROAD GREENFIELD, IN46140

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 28, March 1, 2, 3, & 4, 2011 Facility number: 005954 Provider number: 155767 AIM number: N/A Survey team: Angel Tomlinson RN TC Sharon Lasher RN [February 28, March 1, 2, & 3, 2011] Barbara Gray RN Leslie Parrett RN Census bed type: SNF: 48 Residential: 33 Total: 81 Census payor type: Medicare: 23 Other: 58 Total: 81 Sample: 12 Residential sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	This Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility.We respectfully request paper compliance for this Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 3/11/11 by Jennie Bartelt, RN.			

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F0272 SS=D	Based on observation, interview and record review the facility failed to ensure a wound to the resident's foot was assessed following removal of a callus by the podiatrist. The deficient practice affected 1 of 2 residents reviewed related to wound care in a sample of 12 (Resident #30). Findings include: During observation on 3-1-11 at 2:05 p.m. Resident #30 was sitting in the common area of the facility in an wheelchair with a shoe on the left foot and only a sock on the right foot. Review of the record of Resident #30 on 3-1-11 at 2:10 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer- dementia, depression, osteoarthritis, deaf, blind in the right eye and rheumatoid arthritis. The Minimum Data Set (MDS)	F0272	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident's foot was assessed by the charge nurse during the survey with documentation of assessment included in the resident's record at that time.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents with wounds and/or "other" skin issues will be audited to ensure assessment and documentation of assessment is complete in the resident's record.Measures put into place and sytemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses will be inserviced on the Other Skin Assessment Guidelines (see Exhibit A).How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Weekly audits of all residents with wounds and/or other skin issues will be conducted to ensure proper assessment and documentation is in place. The audits will be conducted for four weeks to ensure compliance, then conducted randomly and reported through the campus Quality Assurance Committee. The Director of Health Services is responsible to ensure compliance.	04/03/2011

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	assessment for Resident #30 dated 2-21-11 indicated the following: is the resident at risk of developing pressure ulcers- yes, were pressure ulcers present prior to admission- no, foot problems- none marked. The "RESIDENT FIRST CONFERENCE NOTES," dated 2-24-11, indicated there were no areas of skin impairment and the right foot was being monitored for skin breakdown. The "Podiatry Examination and Treatment Note" for Resident #30, dated 12-7-10, indicated the resident had an open sore on the right foot, a treatment order was written, and the nurse was notified. The note was signed by the podiatrist. The December 2010 Medication Administration Record (MAR) for Resident #30 indicated the treatment was signed off 12-11-10, 12-12-10 and 12-18-10 as			

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	completed, for 3 days of 8 days. The MAR indicated the order was discontinued on 12-19-10. The MAR indicated the weekly skin assessment signed for 12-8-10, 12-15-10, 12-22-10 and 12-29-10 indicated no areas of skin impairment. The MAR for Resident #30 dated January 2011 indicated on the weekly skin assessments as no areas of skin impairment. The MAR for Resident #30 dated February 2011 indicated the following on the weekly skin assessments: 2-2-11- no areas of skin impairment, 2-9-11- existing area (no indication of location), 2-16-11 - no areas of skin impairment, and 2-23-11 was not signed off that an assessment was completed. Resident #30's record indicated no "Other Skin Impairment Assessment" sheet was initiated or			

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	completed on the resident's right foot ulcer found by the podiatrist on 12-7-10. The Podiatry Examination and Treatment Note for Resident #30, dated 2-14-11, indicated the lateral aspect of the 5th metatarsal (outer aspect of the foot) was dressed and being treated on the right foot. The note was signed by the podiatrist. During observation on 3-2-11 at 9:10 a.m., Resident #30 was sitting the common area of the facility in an wheelchair with a shoe on the left foot and only a sock on the right foot. Interview with Unit Manager #2 at this time indicated the facility left the right shoe off of the resident because the resident had seen the podiatrist and he had taken off a callus on the right foot and a shoe bothered it. Interview with Unit Manager #2 on 3-3-11 at 9:40 a.m. requested an observation of Resident #30's right			

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	foot. Interview with Unit Manager #2 on 3-3-11 at 10:50 a.m., indicated she had to notify the physician on 3-2-11 because Resident #30 had a wound on the right foot and it had yellow drainage coming from it. The Unit Manager #2 indicated she received a treatment order for the resident's right foot from the physician today. During observation at this time with Director of Nursing (DON) present, Resident #30 had a dressing on the outer aspect of the middle area of the right foot. Unit Manager #2 took off the dressing and there was a dark brown colored circle area with a small hole in it, the surrounding tissue was red and inflamed. The dressing that was taken off had a small amount of yellow drainage. The right foot was dry and scaly. The DON asked the resident if the right foot hurt and the resident indicated that it did hurt. The DON indicated she was			

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	going to get the physician in the building to come look at Resident #30's foot. The physician indicated to continue with the current treatment and monitor for improvement. The Change in Condition form notification to the physician for Resident #30, dated 3-2-11 (no time), indicated the resident "had an open area to the right outer foot where the podiatrist removed a callus that is progressing very slowly. The open area measured 1.8 by 1.8 by 0.1 cm. There is a small amount of yellow drainage. May we have an order for bacitracin and border gauze and change three times a day after cleaning with wound cleanser for 14 days and then re-evaluate the wound." The physician response dated 3-3-11 indicated Optifoam dressing, change every three days and as needed. Interview with Unit Manager #2 on			

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	3-3-11 at 11:15 a.m., indicated the weekly skin assessments on Resident #30's Medication Administration Record (MAR) had been signed off by nurses as no skin impairment. Unit Manager #2 indicated there was no skin assessment documentation of the wound except the one she started on 3-2-11. The "Other Skin Impairment Assessment" for Resident #30, dated 3-2-11 (no time), indicated the following: the resident's outer aspect of the right foot had an 1.8 centimeter (cm) length by 1.8 centimeter width and 0.1 centimeter depth area that was yellow in color with irregular wound margins. The area was draining yellow and was painful to touch. The area's surrounding tissue was pink. Interview with the DON on 3-3-11 at 12:05 p.m. indicated there was no skin impairment assessment of Resident #30's ulcer on the right			

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	foot. The DON indicated the floor nurse or the unit manager should have initiated one when the area was identified on 12-7-11. The "OTHER SKIN ASSESSMENT GUIDELINES" provided by the DON on 3-3-11 at 2:10 p.m., indicated the following: the purpose was to "describe and monitor the healing process of skin impairments other than pressure or stasis ulcers." The procedure was to document in black ink by an RN/LPN as part of the resident's permanent record. The form was to be completed for each impaired area and "All measurements are recorded in centimeters. Initiate the form when an area of impairment is identified. Document the length, width, depth, exudate, color, odor, wound margins, surrounding tissue and tunneling. Update the form weekly with current treatment, medical interventions and comments as needed. Note 'healed' when the wound no longer requires			

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	treatment and monitoring." 3.1-31(a)			

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F0282 SS=D	Based on observation and record review, the facility failed to follow a physician's order for Santyl to a resident's right foot following the removal of a callus by the podiatrist for 1 of 2 residents sampled for wound care in a total sample of 12 (Resident #30). Findings include: During observation on 3-1-11 at 2:05 p.m. Resident #30 was sitting in the common area of the facility in an wheelchair with a shoe on the left foot and only a sock on the right foot. Review of the record of Resident #30 on 3-1-11 at 2:10 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer dementia, depression, osteoarthritis, deaf, blind in the right eye and rheumatoid arthritis. The Minimum Data Set (MDS) assessment for Resident #30, dated	F0282	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: The resident's treatment order was clarified with the attending physician during the survey, resulting in a new treatment order implemented by nursing.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents with wounds and/or "other" skin issues' charts will be audited to ensure physician orders are properly recorded and documented by licensed nurses. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses will be inserviced on the Specific Medication Administration Procedures (see Exhibit B) to ensure physician orders are properly recorded and documented. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Weekly audits, conducted five times weekly for four weeks, will review residents with wounds and/or "other" skin issues' documentation to ensure compliance. After four weeks the audits will be conducted randomly and reported through the campus Quality Assurance committee. The Director of Health Services is	04/03/2011

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	2-21-11, indicated the following: making self understood-understood, ability to understand others-sometimes understands, transfer- extensive assistance of one person, bathing-total dependence, mobility devices- wheelchair, is the resident at risk of developing pressure ulcers- yes, were pressure ulcers present prior to admission-no, foot problems- none marked. The "Podiatry Examination and Treatment Note" for Resident #30, dated 12-7-10, indicated the resident had an open sore on the right foot, a treatment order was written and the nurse was notified. The note was signed by the podiatrist. The physician order for Resident #30, dated 12-7-10, indicated to rinse the ulcers on the lateral aspect of the 5th metatarsal head (outer aspect of the upper part of the foot) and the 5th metatarsal base (outer aspect of the middle part of the		responsible to ensure compliance.	

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	foot) on the right foot once a day with normal saline solution and then apply Santyl (debridement medication that digests necrotic tissue) and cover with Kerlix. The resident was not to wear the right shoe until healed. The physician order was signed by the podiatrist. The December 2010 Medication Administration Record (MAR) for Resident #30 indicated the Santyl treatment was signed off 12-11-10, 12-12-10 and 12-18-10 as completed, for 3 days of 8 days. The MAR indicated the order was discontinued on 12-19-10. The MAR indicated the weekly skin assessment signed for 12-8-10, 12-15-10, 12-22-10 and 12-29-10 indicated no areas of skin impairment. The physician telephone order for Resident #30, dated 12-19-10 (no time), indicated to discontinue the Santyl treatment to the right foot and continue to leave off the right			

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	shoe. The resident's record did not indicate an assessment related to discontinuing the Santyl treatment. 3.1-35(g)(2)			

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F0309 SS=D	Based on observation, interview and record review the facility failed to assess and treat a resident's right foot following removal of a callus by the podiatrist. The deficient practice affected 1 of 2 residents reviewed for wound care in a total sample of 12 (Resident #30). Findings include: During observation on 3-1-11 at 2:05 p.m., Resident #30 was sitting in the common area of the facility in an wheelchair with a shoe on the left foot and only a sock on the right foot. Review of the record of Resident #30 on 3-1-11 at 2:10 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer dementia, depression, osteoarthritis, deaf, blind in the right eye and rheumatoid arthritis. The Minimum Data Set (MDS) assessment for Resident #30, dated	F0309	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident's foot was assessed during the survey by the charge nurse with documentation of assessment included in the resident's record.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents with wounds and/or "other" skin issues will be audited to ensure proper assessment and documentation is present.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses will be inserviced on Other Skin Assessment Guidelines (Exhibit A).How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Weekly audits of resident with wounds and/or "other" skin issues will be conducted for four weeks to determine ongoing compliane. After four weeks audits will be conducted randomly and reported through campus Quality Assurance committee. The Director of Health Services is responsible to ensure compliance.	04/03/2011

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	2-21-11, indicated the following: making self understood-understood, ability to understand others-sometimes understands, transfer- extensive assistance of one person, bathing-total dependence, mobility devices- wheelchair, is the resident at risk of developing pressure ulcers - yes, were pressure ulcers present prior to admission - no, foot problems - none marked. The alteration in comfort (arthritis) care plan for Resident #30 indicated an intervention was added on 12-28-10 of no shoe on the right foot. The assistance with daily living care plan for Resident #30 indicated an intervention was added on 12-28-10 of no shoe on the right foot. The "RESIDENT FIRST CONFERENCE NOTES," dated 2-24-11, indicated there were no areas of skin impairment and the			

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	right foot was being monitored for skin breakdown. The "Podiatry Examination and Treatment Note" for Resident #30, dated 12-7-10, indicated the resident had an open sore on the right foot, an order was written and the nurse was notified. The note was signed by the podiatrist. The physician order for Resident #30, dated 12-7-10, indicated to rinse the ulcers on the lateral aspect of the 5th metatarsal head (outer aspect of the upper part of the foot) and the 5th metatarsal base (outer aspect of the middle part of the foot) on the right foot once a day with normal saline solution and then apply Santyl (debridement medication that digests necrotic tissue) and cover with Kerlix. The resident was not to wear the right shoe until the area was healed. The physician order was signed by the podiatrist.			

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	155767	A. BUILDING _____ B. WING _____	03/04/2011

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	The December 2010 Medication Administration Record (MAR) for Resident #30 indicated the Santyl treatment was signed off as completed on 12-11-10, 12-12-10 and 12-18-10, for 3 days of 8 days. The MAR indicated the order was discontinued on 12-19-10. The MAR indicated the weekly skin assessment signed for 12-8-10, 12-15-10, 12-22-10 and 12-29-10 indicated no areas of skin impairment. The physician telephone order for Resident #30, dated 12-19-10 (no time), indicated to discontinue the Santyl treatment to the right foot and continue to leave off the right shoe. The resident's record did not indicate an assessment related to discontinuation of the Santyl treatment. The MAR for Resident #30, dated January 2011, indicated on the weekly skin assessments as no areas of skin impairment.			

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	The MAR for Resident #30, dated February 2011, indicated on the weekly skin assessments the following: 2-2-11- no areas of skin impairment, 2-9-11- existing area (no indication of location), 2-16-11 - no areas of skin impairment, and 2-23-11 was not signed off that an assessment was completed. Resident #30's record indicated no "Other Skin Impairment Assessment" sheet was initiated or completed on the resident's right foot ulcer found by the podiatrist on 12-7-10. The Podiatry Examination and Treatment Note for Resident #30, dated 2-14-11, indicated the lateral aspect of the 5th metatarsal (outer aspect of the foot) was dressed and being treated on the right foot. The note was signed by the podiatrist. During interview with the DON on 3/3/11 at 12:05 p.m., she indicated she talked to the Podiatrist caring			

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	for the resident. The DON indicated the Podiatrist said he didn't assess the resident's wound on 2/14/11 was because it had a dressing on it. During observation on 3-2-11 at 9:10 a.m., Resident #30 was sitting the common area of the facility in an wheelchair with a shoe on the left foot and only a sock on the right foot. Interview with Unit Manager #2 at this time indicated the facility left the right shoe off of the resident because the resident had seen the podiatrist and he had taken off a callus on the right foot and a shoe bothered it. During interview with Unit Manager #2 on 3-3-11 at 9:40 a.m., an observation of Resident #30's right foot was requested. Interview with Unit Manager #2 on 3-3-11 at 10:50 a.m., indicated she had to notify the physician on 3-2-11, because Resident #30 had a			

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	wound on the right foot and it had yellow drainage coming from it. The Unit Manager #2 indicated she received a treatment order for the resident's right foot from the physician today. During observation at this time with Director of Nursing (DON) present, Resident #30 had a dressing on the outer aspect of the middle area of the right foot. Unit Manager #2 took off the dressing, and there was a dark brown colored circle area with a small hole in it, the surrounding tissue was red and inflamed. The dressing that was taken off had a small amount of yellow drainage. The right foot was dry and scaly. The DON asked the resident if the right foot hurt and the resident indicated that it did hurt. The DON indicated she was going to get the physician in the building to come look at Resident #30's foot. The physician came in Resident #30's room and queried about what kind of treatment was being done for the resident's right			

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	foot. The Unit Manager #2 indicated an Optifoam dressing was being done and the resident was currently on Omnicef (antibiotic) for an urinary tract infection. The physician indicated to continue with the current treatment and monitor for improvement. The change in condition form notification to the physician for Resident #30, dated 3-2-11 (no time), indicated the resident had an "open area to the right outer foot where the podiatrist removed a callus that is progressing very slowly. The open area measured 1.8 by 1.8 by 0.1 cm. There is a small amount of yellow drainage. May we have an order for Bacitracin and border gauze and change three times a day after cleaning with wound cleanser for 14 days and then re-evaluate the wound." The physician response dated 3-3-11 indicated Optic foam dressing, change every three days and as needed.			

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Interview with Unit Manager #2 on 3-3-11 at 11:15 a.m., indicated the weekly skin assessments on Resident #30's Medication Administration Record (MAR) had been signed off by nurses as no skin impairment. Unit Manager #2 indicated there was no skin assessment documentation of the wound except the on she started on 3-2-11.

The "Other Skin Impairment Assessment" for Resident #30, dated 3-2-11 (no time), indicated the following: the resident's outer aspect of the right foot had an 1.8 centimeter (cm) length by 1.8 centimeter width and 0.1 centimeter depth area that was yellow in color with irregular wound margins. The area was draining yellow and was painful to touch. The area's surrounding tissue was pink.

Interview with the DON on 3-3-11 at 12:05 p.m., indicated there was

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	no skin impairment assessment of Resident #30's ulcer on the right foot. The DON indicated the floor nurse or the unit manager should have initiated one when the area was identified on 12-7-10. Review of the "OTHER SKIN ASSESSMENT GUIDELINES" provided by the DON on 3-3-11 at 2:10 p.m., indicated the following: the purpose was to "describe and monitor the healing process of skin impairments other than pressure or stasis ulcers." The procedure was to document in black ink by an RN/LPN as part of the residents permanent record. The form is to be completed for each impaired area. "All measurements are recorded in centimeters. Initiate the form when an area of impairment is identified. Document the length, width, depth, exudate, color, odor, wound margins, surrounding tissue and tunneling. Update the form weekly with current treatment, medical interventions and comments as			

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	needed. Note 'healed' when the wound no longer requires treatment and monitoring." 3.1-37(a)			

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F0323 SS=D	Based on observation, interview and record review, the facility failed to provide interventions to prevent injury from falls for 1 of 6 residents reviewed for falls in a sample of 12. (Resident #10) Findings include: Resident #10's record was reviewed on 2/28/11 at 12:20 p.m. Resident #10's diagnoses included, but were not limited to, osteoporosis and left arm fracture. Resident #10's "Care Area Assessment" dated 2/21/11, indicated "was on our assisted living side when more debility noted/fell fractured left wrist and went to (local hospital). Was admitted to health care side related to fracture/debility." Interview with the Director of Nursing (DON) on 2/28/11 at 1:15 p.m., indicated Resident #10 was on the assisted living side of the	F0323	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident's personal alarm was added to her recliner chair during the survey and staff reminded to ensure call light was available at all times.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents with personal alarms will be audited to ensure placement of alarm according to their plan of care.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses wil be inserviced on the Falls Management Program Guidelines (Exhibit C) to ensure implementation of personal alarms is consistent in documentation in plan of care, nursing assignment sheet, and actual implementation for resident safety. How the corrective measures will be monitored to ensure the alleged deficient pratice does not recur: Five randomly selected residents will be audited weekly for four weeks to ensure compliance with personal alarm placement in accordance with resident's plan of care and nursing assignment sheet. After four weeks, random audits will be conducted and reported through campus Quality	04/03/2011

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	facility when she fractured her arm on 2/5/11 and was sent to the hospital. The DON indicated when she was discharged from the hospital on 2/8/11, due to multiple falls and her decline, she was admitted to the health care side of the facility. On 2/28/11 at 1:10 p.m., Resident #10 was observed sitting upright in her recliner chair without an alarm in her chair. On 3/2/11 at 10:30 a.m., Resident #10 was sitting upright in her recliner chair without an alarm in her chair, and her call light was not in reach. Interview with staff LPN #1 on 3/2/11 at 1:20 p.m., indicated the resident does not have an alarm in her chair but just when she is in bed and in her wheelchair. Resident #10's Minimum Data Set (MDS), assessment, dated 2/15/11,		Assurane committee. The Director of Health Services is responsible to ensure compliance.	

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	indicated the following: "- ability to express ideas and wants, understood - ability to understand others, understands - short term memory, memory problem - transfer, extensive assistance with two persons physical assist - walk in room, extensive assistance, with two person physical assist - walk in corridor, activity did not occur - did the resident have a fall any time in the last month prior to admission, yes - did the resident have a fall any time in the last 2-6 months prior to admission, yes - did the resident have any fracture related to a fall in the 6 months prior to admission, yes." Resident #10's "Fall Circumstance, Assessment and Intervention" indicated the following falls prior to admission to the facility:			

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	"- 1/19/11 at 6:20 p.m., leaning over to pick up object off of floor lost balance - 1/24/11 at 3:30 p.m., resident was found sitting on floor on buttocks - 2/3/11 at 12:15 a.m., (location of fall not on circumstance assessment) - 2/5/11 at 11:35 p.m., (location of fall not on circumstance assessment)." Resident #10's x-ray of left wrist dated 2/6/11 indicated fractures of the left wrist. Resident #10's care plan dated 2/21/11, indicated "problems at risk for fall/injury history of falls potential for fall, fractured left wrist. Goal, resident will have reduced risk of fall related injury by utilizing fall precautions. Interventions include but are not limited to, call light in reach provide/monitor use of adaptive devices, wheelchair. Intervention added 2/9/11, bed/chair alarms."			

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	Resident #10's physician recapitulation orders dated 3/1/11, indicated devices: chair alarm. Interview with the DON on 3/3/11 at 10:00 a.m. regarding Resident #10's falls indicated the fall on 2/3/11 was from her recliner, and the fall on 2/5/11 was from her chair in her room. She also indicated Resident #10 has an alarm in her chair now. 3.1-45(a)(2)			

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F0371 SS=F	Based on observation, and interview and record review, the facility failed to label and date opened, and cooked foods placed in a refrigerator, and freezer in the kitchen, and failed to monitor and have chemical sanitation buckets at appropriate parts per million in the kitchen. This practice had the potential to affect 48 of 48 residents who are served their meals from the kitchen. Findings include: An initial tour of the facility kitchen was conducted on 2/28/11 at 11:18 A.M., with the Director of Food Services, and the following was observed: The walk in freezer contained the following foods that had been opened or cooked with no label or open date placed on the outside of the container: a plastic container of cooked vegetable soup, a plastic container of cooked green beans, a liter of diet coke, a resident's personal box of 4 fudge	F0371	Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: The unmarked food items were removed from the walk-in freezer and refrigerator during the walk-through with the surveyor. Two new sanitizing buckets were prepared after the walk-through with the surveyor and tested appropriately. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Director of Food Services audited both walk-ins and reach-ins to ensure all items properly identified and dated at conclusion of walk-through with surveyor, in addition to preparing new sanitizing solutions and recording their PPM. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary staff inserviced on policy for Leftover Foods (Exhibit D), in addition to preparing, testing and documenting the PPM for the sanitizing buckets and 3-compartment sink.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Director of Food Services, Assistant Director, and Cooks are responsible to monitor on a daily basis to ensure leftover foods are labeled and dated appropriately,	04/03/2011

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	sickles, 3 residents personal boxes of ice cream, 4 large containers of ice cream, a bag of onion rings, a bag of hashbrowns, a box of cheesecake containing 7 slices, and 2 containers of strawberries. The walk in refrigerator had a box containing 35 mighty shakes. Instructions on the mighty shakes indicated to store frozen - thaw at or below 40 degrees. Use thawed product within 14 days. Keep refrigerated. An interview with the Director of Food Services indicated the items were not labeled or dated. At 11:25 A.M., 2 buckets used to clean in the kitchen were tested for chemical sanitizer. Both cleaning buckets tested read 0 parts per million (ppm). The Hydro Sink Master attached to the sink faucet, that dispensed the chemical sanitizer was tested and read 400 ppm. An interview with the Director of Food Services indicated both buckets tested 0 ppm, and the sink tested at 400 ppm. The same 2		in addition to ensuring proper preparation and documentation of sanitizing buckets and 3-compartment sink. Director will report findings through the campus Quality Assurance committee monthly. Director of Food Services maintains overall responsibility for compliance.	

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	buckets were re-tested for chemical sanitizer at 11:55 A.M. Both buckets read 0 parts per million. A fresh bucket of chemical sanitizer was dispensed into a bucket from the sink, and the chemical sanitizer tested 400 ppm. An interview with the Director of Food Services indicated the buckets read 0 ppm, had not been changed yet, and the sink sanitizer tested 400 ppm. The Director of Food Services indicated the buckets with chemical sanitizer should be changed approximately every 45 minutes to 1 hour. The Director of Food Services indicated the chemical sanitation for the buckets and sink should be 200 ppm. The Director of Food Services indicated the buckets and sink should be tested for chemical sanitizer prior to each meal and documented. A review of the manual ware washing (3 - bay sink) concentration record indicated the sink, and bucket chemical sanitizer had been tested and documented for one supper meal on 2/19/11. No			

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	other chemical sanitation tests were documented for February, 2011. An interview with The Director of Food Services on 3/4/11 at 10:15 A.M., indicated all residents are served their meals from the kitchen. Review of the most current Handling of Leftover Food policy provided by the Executive Director on 3/1/11 at 9:30 A.M., indicated the following: Policy - "Leftover foods will be utilized in an appropriate and safe manner to aid in controlling waste." Procedure - 2.) "Leftovers should be covered, dated, labeled, and refrigerated as soon as meal service is finished and cooled to below or at 70 degrees within 2 hours and below or at 41 degrees within 4 hours." 3.) "Refrigerated leftovers should be used within 72 hours after opening or be frozen." 6.) "Leftovers which are frozen are covered so that they are air-tight and moisture proof." "They are labeled with item			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING _____ B. WING _____	03/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN ROAD GREENFIELD, IN46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and date." 8) "All personnel cooking are aware of what foods are leftover and how to use them." "The Dining Service Manager or Cook checks for leftovers each morning and determines how to use them." 3.1-21(i)(2)			